

**Wisconsin Public Employers' Group Life Insurance Program
Continuation Application**

Section 40.72(4), Wis. Stat.

EMPLOYER: This application is intended for insured employees who are terminating Wisconsin Retirement System (WRS) employment, who may qualify to continue life insurance coverage, and who will not begin a WRS retirement benefit immediately. **Complete Parts A, B and C. Make a copy for your records and give the application to the employee.**

EMPLOYEE: If you are under age 65, your group life insurance coverage will cease at the end of the month following the month your employment terminates, or 30 days after the expiration of an approved leave of absence. You may continue your group term life insurance coverage if you meet the eligibility criteria and complete this application form. **If you do not apply, your coverage may lapse and cannot be reinstated.**

➤ **What is continuation coverage?**

Continuation is an inexpensive way to maintain full group term coverage until age 65, and a reduced amount of Basic coverage after age 65. Basic coverage is required in order to continue Supplemental or Additional coverage and you may continue only the coverage that is in effect when you terminate employment. Spouse and Dependent coverage cannot be continued.

➤ **Who is eligible to apply for continuation coverage?**

Complete the "Employee" section of the form to determine if you are eligible to continue group term life insurance coverage.

Note: Do not file this form if you will begin a WRS retirement benefit (annuity or lump sum, but not a separation benefit) within 31 days after life insurance coverage ends. The Department will determine your eligibility and will automatically arrange for continued premium payments through annuity deduction when you apply for a retirement benefit.

➤ **How much does it cost?**

When you continue group coverage, you pay premiums at the group rate that is in effect for your age and coverage amount. Premiums are due until age 65.

➤ **How do I apply?**

If you believe you are eligible to continue your group life insurance coverage:

- A. Your employer must complete the "Employer" section of the form.
- B. Complete the "Employee" section of the application and sign it.
- C. Send the application to the Department of Employee Trust Funds at the address shown above.

The Department must receive your application for continuation coverage no later than 31 days after your group life insurance coverage ends.

➤ **What if I'm not eligible for continuation coverage?**

If you do not meet the eligibility requirements for continuation coverage, you may be eligible for **Conversion** coverage. Conversion to an individual whole life policy is more expensive than group term coverage; however, the policy builds cash value and the coverage amount will not decrease in the future. You can convert all or a portion of your coverage. Your spouse and/or dependents who are insured under the Spouse and Dependent plan can also convert their coverage.

To be eligible for conversion, you must have been covered by the group plan for at least six continuous full months at the time group coverage ends. To convert your group term coverage to a whole life policy, you must apply and pay the first premium no later than 31 days after your group coverage ends. Call Minnesota Life at (608) 277-8690 to request *Conversion Information for State of Wisconsin and Public Employers' Group Life Insurance* (ET-2306).

DEPARTMENT OF EMPLOYEE TRUST FUNDS

P.O. Box 7931
Madison, WI 53707-7931

CONTINUATION APPLICATION**Group Life Insurance**

Section 40.72 (4), Wis. Stat.

EMPLOYER: Complete the information in Parts A, B, and C below. Keep a copy for your records, then give the entire form, including the cover sheet, to the employee.

A. EMPLOYEE NAME (Last, first middle, maiden/former)			Social Security Number	
Date Employment Began With This Employer (MM/DD/CCYY)	Date Employment Terminated With This Employer (MM/DD/CCYY)	Birthdate (MM/DD/CCYY)		SEX <input type="checkbox"/> M <input type="checkbox"/> F
Last Coverage Month For Which Premiums Were Paid: <small>(Premiums are for the month of termination and the following month. Refund any premiums paid for later months.)</small>		Previous Calendar Year WRS Earnings \$ _____ Year		

B. CURRENT COVERAGE AMOUNT AND ANNUAL PREMIUM

PLAN		MONTHLY PREMIUM	CURRENT ANNUAL PREMIUM
BASIC	\$	\$	X 12 = \$
SUPPLEMENTAL	\$	\$	X 12 = \$
ADDITIONAL	\$	\$	X 12 = \$
TOTAL COVERAGE	\$		TOTAL PREMIUM \$

- C.** I understand that Wis. Stat. § 943.395 provides criminal penalties for knowingly making false or fraudulent claims on this form and hereby certify that to the best of my knowledge and belief, the information is true and correct.

Date Prepared (MM/DD/CCYY)	Employer Agent Signature		
Prepared By	Telephone Number ()	ETF Employer Number 69-036-	
Employer Name/ WI Department of		Local Employer Billing Unit No.	

EMPLOYEE: Complete the information below, sign and date the form, and return it to the Department of Employee Trust Funds within 31 days after the date your insurance coverage ends. Make a photocopy for your records.

1. Check any of the statement(s) that apply to you:

- ☐ I was covered under the Wisconsin Retirement System (WRS) before 1990.
☐ I was covered under the group life insurance plan for a part of at least 5 calendar years.

If you checked either statement, go to question 2. If neither statement applied to you, you do not qualify to continue the insurance.

2. Check any of the statement(s) that apply to you:

- ☐ I meet all the requirements for receiving an immediate WRS annuity except filing the application.
☐ The sum of my creditable years of WRS service before January 1, 1990 plus the number of years I have participated in the life insurance plan beginning on January 1, 1990 equals 20 years.
☐ The number of years I have been employed with my last employer is 20 years or more.

If you did not check any of the above, you do not qualify to continue life insurance. If you checked at least one of the above, you qualify to continue the life insurance. If you qualify, please answer questions 3 and 4 below.

3. I want to continue all of my current coverage listed above in Section B. ☐ Yes ☐ No*

*If you answered "No", please complete and attach an *Application Cancellation/Refusal* form (ET-2304) indicating which coverage you wish to cancel.

4. I prefer to be billed: ☐ Annually ☐ Semiannually

Premiums are due until age 65. They are based on the current rates in effect for your age group.

5. Certification/signature: I have read the entire "Continuation Application" and I understand it. I wish to continue my group life insurance coverage. I understand that if I fail to pay premiums in the future, my insurance coverage will lapse on the last day for which premiums were paid and will not be reinstated unless premiums are paid within 30 days. I understand that Wis. Stat. § 943.395 provides criminal penalties for knowingly making false or fraudulent claims on this form and hereby certify that to the best of my knowledge and belief, the information is true and correct.

Date (MM/DD/CCYY)	Employee Signature		Telephone Number (8 a.m. – 4 p.m.)	
Address	Street	City	State	Zip